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Exploring the Client-Therapist Relationship in Music Therapy:

A Qualitative Study in Adult Mental Healthcare

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Received 18 April 2023; Accepted 24 June 2023; Published 1 November 2023
Editor: Nami Yoshihara
Reviewers: Amanda MacRae, Tina Stone

Abstract

Introduction: Most of the existing literature on the therapeutic relationship in music therapy rests on the researcher's point of view. Hence, there is a limited amount of research that focuses on what creates a helpful client-therapist relationship from the client's perspective. This study aimed to explore what participants from various psychiatric units at different hospitals in Norway find to be helpful characteristics in the client-therapist relationship in music therapy.
Method: Four participants were interviewed using in-depth semi-structured interviews focusing on their perspectives on what creates a helpful client-therapist relationship in music therapy. Through the use of interpretative phenomenological analysis, two super-ordinate themes, each with four following subordinate themes, were developed.
Results: Two super-ordinate themes were developed, namely "Power relations" and "Feeling safe and being challenged." The participants expressed that "to not feel judged," "the use of layman's language," "informality, flexibility, and collaboration in treatment," as well as "trust" and "honesty" are important elements for a helpful client-therapist relationship.
Discussion: The findings presented in this article, are discussed in relation to theory from psychology, music therapy, and previous studies from the field of mental healthcare. All participants spoke about previous experiences of power imbalance in mental health care. The findings suggest that a relationship that is based on *equality* and *mutual respect* contributes to a feeling of *trust* – all of which are proposed as helpful characteristics in the client-therapist relationship in music therapy.

Keywords: user perspective, music therapy, mental health, client-therapist relationship, trusting relationship, power relations

Publisher: GAMUT - Grieg Academy Music Therapy Research Centre (NORCE & University of Bergen)

DOI: https://doi.org/10.15845/voices.v23i3.3931

Introduction

The importance of the client-therapist relationship and how it affects therapy in mental healthcare has been emphasised in both psychotherapy and music therapy literature for decades. Research on various factors, referred to as *common factors*, documents their effect on the therapeutic outcome in the mental health and psychotherapy field. Specifically, some of these factors include therapeutic alliance, empathy, emotional experience, and genuineness (Cuijpers et al., 2019; Nahum et al., 2019; Wampold, 2013; Wampold & Budge, 2012). The therapeutic alliance – which is of particular interest for this study – may be defined as a working relationship between client and therapist (Nahum et al., 2019).

Numerous studies demonstrate that the quality of the client-therapist relationship is closely linked to the effectiveness of the therapy (Barkham et al., 2021). In fact, research studies on service users' experiences in mental health services stress the importance of this and identify characteristics that are helpful to create a therapeutic alliance (Borg & Kristiansen, 2004; Gilburt et al., 2008). Generally, within the field of music therapy, a range of theoretical perspectives promote relational qualities such as collaboration, equality, and mutuality. For example, humanistic perspectives (Ruud, 2010) such as resource-oriented music therapy (Rolvsjord, 2010), community music therapy (Stige & Aarø, 2012; Stige et al., 2010), recovery perspectives (McCaffrey et al., 2018; Solli et al., 2013) and feminist perspectives (Hadley, 2006), challenge power relations (Rolvsjord, 2016), which is the overall theme of this study. Additionally, some music therapy literature explicitly suggests that relational qualities between the client and the music therapist may affect the therapeutic outcome (John, 1995; Rolvsjord, 2010; Trondalen, 2016).

However, what a therapeutic relationship inherently entails seems to vary within theoretical perspectives in music therapy. For instance, music-centered (Aigen, 2005) and resource-oriented (Rolvsjord, 2010) music therapy traditions both value the therapeutic relationship, but the concept is presented in contrasting ways. Aigen (2005) describes that "in music-centered music therapy, the mechanisms of music therapy process are located in the forces, experiences, processes, and structures of music" (p. 62). Therefore, in this approach, the client-therapist relationship is based mainly on the musical interaction and the experience itself, which is "the locus of therapeutic effect" (Aigen, 2014, p. 94). Alternatively, Rolvsjord (2010) explains a resource-oriented approach to music therapy as:

> An approach … that emphasizes the development of strengths and resources as part of [the] therapeutic encounter, that strive toward equal relationship, that emphasize cultural awareness and societal engagement, and that emphasize the possibilities of the use of music as a health resource. (p. 16)

The client-therapist relationship in this approach is explained to be equal rather than hierarchical, and the musical interactions are not the primary focus of the relationship. The theoretical framework Rolvsjord employs for this approach is based on elements from different philosophies and conceptualisations of approaches that challenge the "illness ideology[1]," including empowerment philosophy, positive psychology, and the common factors approach (Rolvsjord, 2010).

The different conceptualisations of the client-therapist relationship in music therapy can be understood by looking at Bruscia's (2014) distinction between music *as* therapy and music *in* therapy. In music *as* therapy, "music serves as the primary medium and agent for therapeutic change" and the therapist serves as "the guide or facilitator who has the expertise needed to present the appropriate music or music experience to the client" (p. 45). Music-centered music therapy falls under this approach. In music *in* therapy, music is used both for its healing powers and as an effect-enhancement of the client-therapist relationship. In this way, "the therapist's main goal is to address the needs of the client

through whatever medium seems most relevant or suitable, whether it is music, the relationship, or other therapeutic modalities" (pp. 45–46). These values are congruent with resource-oriented music therapy (Rolvsjord, 2010).

In Norway, the concept of user involvement is continuously gaining importance. While for years it has been a statutory right (Helsedirektoratet, 2022), it has in recent times expanded in terms of how and to what degree the clients are involved in their treatment plan (Odden, 2018). For instance, there have been created positions for peer workers in mental health and substance use services, where the person's own experiences and reflections are of importance (Øverbø, 2017). The value of user involvement is also recognised and addressed, either explicitly or implicitly, in the music therapy literature from different approaches and perspectives such as resource-oriented music therapy, the recovery orientation, and community music therapy (see e.g., Rolvsjord, 2010; Solli, 2014; Stige & Aarø, 2012[2]).

The amount of empirical research with user perspectives focusing on the effect and experiences of music therapy in mental healthcare has grown in the last decade (Ansdell & Meehan, 2010; McCaffrey, 2018; McCaffrey & Edwards, 2016; Paul et al., 2020; Rolvsjord, 2018; Silverman, 2006; Solli et al., 2013; Solli & Rolvsjord, 2014). For example, Tuastad et al. (2022) conducted a study using the user interviewing user method to map participants' experiences of stigma, and McCaffrey et al. (2021) explored participants' experiences of songwriting in recovery-oriented mental health services. Also, Rolvsjord (2015; 2016) has conducted studies with users' perspectives on their involvement in the therapeutic process and contribution to the client-therapist relationship in music therapy, which is closely congruent with this study. One could, however, still argue that empirical research within the field of music therapy in mental healthcare that draws on user perspectives is limited.

Regardless of the different understandings of the client-therapist relationship, what is perhaps most notable is that most of the existing music therapy literature that specifically contains the topic of the client-therapist relationship – whether it is referred to as the "musical relationship" or "good relational qualities" – highlights the music therapist's own reflections (see e.g., Abrams, 2012; Aigen, 2005, 2014; John, 1995; Priestley, 2012; Trondalen, 2016; Verney & Ansdell, 2010). To get the full picture, the voices of the service users need to be featured as well (Rolvsjord, 2016). Thus, one can say that the current music therapy literature seems to be deficient. There seem to be no current studies in Norway, or internationally, that explicitly focus on the client-therapist relationship in music therapy, interviewing clients about what they need in order to create a therapeutic alliance with their music therapist. Therefore, this study offers a perspective from Norway as a way of offering initial insights into this area. The aim of this article is to explore what characteristics of the client-therapist relationship the clients in psychiatric units at various hospitals in Norway find helpful in treatment.

Method

This study was conducted during the winter and spring of 2022, at psychiatric units in different hospitals in Norway. The data featured in this article is provided by four music therapy outpatients using in-depth semi-structured interviews and is analysed through interpretative phenomenological analysis (IPA). The aim of this study was to get user perspectives on helpful characteristics for the client-therapist relationship in music therapy in mental healthcare.

Participants and setting

The participants were selected purposively by their music therapist as it was anticipated

that they could give insight into their perspectives on the client-therapist relationship in music therapy. It was not possible to have a randomised selection of participants in this study, due to a short time limit and lack of resources. There may be biases in the strategic recruitment of participants for this study, given the involvement of the treating music therapists in selecting participants.

The inclusion criteria that the participants had to meet in order to partake in the study were: (1) had previously participated in a minimum of three music therapy sessions; (2) be 18 years or older; (3) be able to verbally express experiences and reflections in an interview. The researcher considered, in dialogue with the research supervisor, that participation in at least three sessions would probably be the point at which the clients would be familiar with the concept of music therapy and pass the first-impression stage of the client-therapist relationship.

The participants who partook were two women and two men, and they were in the age group 30-50 years old. Two of the participants were in an established band with their music therapist and other clients at their site and did musical performances on public stages outside of therapy. One of the participants had recorded their own songs in a studio at the site and let the researcher listen to several of the songs before starting the interview. The fourth participant mostly liked to sing acapella and harmonise with their music therapist. The participant's music therapists were a mixture of men and women in the age group 30-50 years old, and they all currently work at various psychiatric units in Norway. Recovery-oriented music therapy, resource-oriented music therapy, and community music therapy are – according to the practice experiences of the researcher – the main approaches used by music therapists in the context of mental healthcare in Norway.

All interviews took place at the institutions where the participants had their music therapy sessions, without their music therapist being present. The researcher used isolated rooms containing comfortable sofas, drinks, and snacks. The researcher had conversations with all the participants before starting the interviews, to ensure that the clients knew what was going to happen and to make sure that they were seemingly comfortable.

Data collection

The data for this study was collected through semi-structured interviews with open-ended questions. A flexible interview approach was adopted as an attempt to enable the participants to express their personal opinions about the topic (Brinkmann & Kvale, 2018). The interview guide used in this study was reviewed by other researchers at Grieg Academy Music Therapy Research Centre (GAMUT), and revised several times before coming to fruition. Participant interviews included the following questions:

- How do you experience the relationship between you and the music therapist?
- Do you have any specific keywords that you think are important for a helpful client-therapist relationship in music therapy?
- Do you experience your relationship with the music therapist differently from your relationship with other therapists – and if so, what is the difference?
- Do you have any examples of moments where you felt that you were 'vibing' with the music therapist without communicating with each other verbally?

Some questions required follow-up questions to gain a deeper understanding of their experiences. The participants were interviewed individually, and the interviews lasted 20-50 minutes, depending on the amount of details provided. The interviews were all audio recorded using a hand-held Zoom recorder and then converted to verbatim transcriptions by the researcher. All the interviews were conducted in Norwegian, and the statements used in this article have been translated by the researcher and the research supervisor. They also decided that no follow-up interviews were necessary due to the

comprehensiveness of the initial answers provided by the participants and that saturation was reached after the fourth interview.

Data analysis

The data were analysed using interpretative phenomenological analysis (IPA), where the participants' lived experiences and perceptions are in focus (Smith & Fieldsend, 2021). IPA was a natural choice for this study, given that the researcher wished to explore a phenomenon – the participants' experience of the therapeutic relationship in music therapy. First, the interview transcripts were read through several times, where all relevant and/or interesting parts and initial codes were marked in the right-hand margin with a comment in Microsoft Word. Each of the interviews was then individually transferred into a new document with a table containing "emerging superordinate themes" and "initial codes," where a superordinate theme and a code were temporarily suggested. For example, most statements about experiences of power imbalance in mental healthcare were put in a superordinate theme of "power relations" and associated initial codes could be "bad experiences," "the importance of chemistry," or "the feeling of being judged." After developing, editing, and renaming codes, categories, and superordinating themes, all the transcripts were sorted into a final table of key themes and codes. The writing phase was the final step of the data analysis, where extracts from the table of key themes were put into text. During this analytic interpretative process, there was a constant shifting of focus between "parts" (e.g., looking in detail at sentences and words in each individual interview), and the "whole," where the sum of all that is said in the interviews is interpreted in a bigger context. This constant "zooming in and zooming out" when interpreting the data is often referred to as the hermeneutic circle (Smith, 2007; Smith & Shinebourne, 2012).

Ethical considerations

Prior to the data collection, the study received approval from the Norwegian Centre for Research Data (NSD). The researcher was in contact with the regional committees for medical and health research ethics (REK), and they approved that further ethical approval was not necessary for this study. All the participants signed a letter of informed consent before starting the interviews. The music therapists also had to sign a letter of consent because the participants were referring to them when talking about the client-therapist relationship in the interviews. If the participants had any questions or objections, wanted to get sent a draft of the transcripts, or generally wished to withdraw from this study, they were given the contact info of the researcher, the research supervisor, the data protection officer of the University of Bergen, and the NSD. It was also made clear to the participants that it was okay for them to withdraw from the study without giving any explanation, and that this choice would not impact their access to music therapy or their relationship with their music therapist or the researcher. They were also told that their music therapist could be their communicator with the researcher. None of the participants contacted the researcher subsequently, and they have not seen the result of this study. In many ways, this can be seen as a flaw of this study, and potentially weakens the validity of the findings, as all interpretation of the data material has been done by the researcher, with help from the supervisor and fellow students. The power relations are therefore skewed when publishing this study, as the participants' voices are heard, but on the researcher's terms. A lot of time has therefore been put into the work of the data analysis in order to represent the findings as accurately as possible.

Continuously, the research process has called for reflexivity concerning the degree to which I, as a music therapy student and a researcher, have inherent biases in conducting

this study and how that affects the results of the findings (Stige et al., 2009). Throughout the research process, I was aware of my own pre-understandings, through engaging in peer debriefing, about how I would expect the participants to feel about the client-therapist relationship in music therapy as well as ethical issues of accountability (Miller et al., 2012; Stenbacka, 2001). It is important to reflect upon the power imbalance between the researcher and the participants, and how that may have been affecting the answers in the interviews. The participants were the ones being asked questions about their personal relationships with their music therapists in treatment. This may be a vulnerable position to be in, especially considering that they had just met the researcher, although the role of the researcher was explained to the participants both in the letter of consent and in person when the interviews were taking place. It is also important to note that the music therapists were the ones recruiting their own clients, and that may also have affected the responses represented in this study. The participants may have felt a sense of loyalty towards their music therapist. This might have potentially influenced their answers when talking about their experiences with their music therapist, even though it was clarified that their identity would remain confidential. Lastly, how to systemise, analyse, and present the data in a way that was truthful to the original meaning of the statements from the participants – which inevitably will be coloured by the researchers' own pre-understandings – was continuously discussed and reflected upon with my research supervisor.

Findings

Through the data analysis two main themes related to what the participants classified as essential elements in the client-therapist relationship emerged. The first category of findings consists of the participants' reflections on the superordinating theme of "Power relations," while the second category comprises their reflections on the superordinating theme of "Feeling safe and being challenged." The participants naturally tended to talk about their experiences with their music therapists and used their current relationship as an example of what they found helpful in treatment because they were already satisfied. Whether they expressed that characteristics of their current therapeutic relationship are helpful or that former client-therapist relationships did not work, the findings still suggest what the participants generally find to be helpful characteristics in a client-therapist relationship in music therapy.

Table 1. Taxonomy of Superordinating Themes, Subordinate Themes, and Sample Codes

Main themes	Subordinate themes	Codes
Power relations	Communication	To not feel judged/Layman's language
	Formal versus informal	Chemistry/friendship
	Flexibility	Alternating between music and talking/musical moments
	Collaboration	
Feeling safe and being challenged	First impression	To feel welcome
	Honesty	Honest feedback
	Proceeding cautiously	Vulnerability
	Guidance, competence, and presence	Control

Main Theme 1: Power Relations

A topic that was apparent in all interviews – either explicitly or implicitly – is the experience of power imbalance in mental health care. This topic predominantly emerged through comparing negative experiences with former therapists or health professionals to their experiences with their current music therapist. For instance, negative experiences such as not feeling welcome, not feeling like they can be their authentic selves, not feeling like they are being listened to, and not trusting their therapist were all given as examples by all the participants of what creates a negative client-therapist relationship. One of the participants explained that:

> *My experience is that many psychologists and psychiatrists see things through "stencils." They were trying to hammer me into a "stencil[3]", and when that did not work, I was kicked out [of treatment]. (P4)*

When comparing other therapies to music therapy, participant 2 expressed that music therapy for them is "an alternative gateway" to vulnerable topics, in the sense that vulnerable topics were experienced as easier to open up about in a music therapy setting. Generally, there seems to be a consensus among the participants that music therapy, to a more extensive degree than other therapies in their experience, offers a space where they feel like they can be their authentic selves. When referring to how their current music therapy environment is experienced, one of the participants stated:

> *The client's needs must be the main focus. The clients should be allowed to be themselves. (P4)*

Although all the participants expressed that they are satisfied with their current music therapist, reflections on power imbalance in music therapy were repeatedly discussed by one of the participants in the context of music playing:

> *The feeling that there are those who are so much better than me [talking about musicians in the context of music therapy], that I am just a worm and that they are gods, an extreme hierarchy. (P4)*

More specifically, this participant explained that they would feel uncomfortable or intimidated in a situation where it was made obvious that the music therapist is a more "skilled musician" than them as this could be experienced as degrading. They expressed that music therapists should not have the need to "show off" their musical skills, but rather adapt to the musical level of their clients.

Communication

The word "communication" was brought up by two of the participants when asked if there were any keywords that could describe what was important for them in a client–therapist relationship in music therapy. More specifically, two topics that emerged were "to not feel judged" and the use of "layman's language." For instance, one of the participants talked about how it is essential that the music therapist reassure the clients that they are always welcome, so they do not feel judged:

> *If the therapist is very tired and is sighing and yawning, then they should communicate that they slept poorly the night before. "That's why I'm sighing, it's not you who's tiring" [impersonating the music therapist]. (P4)*

This quote was followed by them explaining that they had indeed experienced this before:

> *One of my former therapists sighed when they went into the break room after my session. I was just like, "Okay, sorry then, am I that exhausting? I won't bother you anymore." (P4)*

The wording that the music therapists choose when talking with their clients, for instance, when discussing mental health conditions, was also an engaging topic among the participants. On the one hand, the language should not be so overcomplicated that it is not understandable:

> *It is important that the music therapist is aware that "this client" [talking about themselves] does not understand technical terms, then "I [the music therapist] must use other words." (P1)*

On the other hand, the language should not be simplified to the extent that it feels degrading to the clients.

> *Layman's language is okay if they don't use baby language. It may work for some people, but there is a balance. If they use baby language, then it feels like they think that I'm stupid. (P4)*

All the participants expressed that they appreciate the way that their music therapists communicate with them, either because the therapist appears accommodating and compassionate in conversations or because they have a casual way of communicating so that it is perceived as friendly.

Formal versus informal

One of the reasons why several of the participants valued their relationship with their music therapist was because it was perceived as more casual compared to their experiences with other therapists. The client-therapist relationship in music therapy is built on different premises than other therapy forms, which is expressed through some of the statements from the participants. The words "friendship" and "chemistry" were mentioned as factors perceived to be beneficial for creating an optimal client-therapist relationship. Some of the participants said that they discuss everyday topics and talk about common interests with their music therapist, which generally makes it less challenging for them to be more vulnerable and open to sharing their feelings because they have a "friendship." For example:

> *I feel like it's a bit like… I feel like it [the client-therapist relationship] is pretty casual. The music therapist is sort of someone I could have been friends with or hung out with outside of treatment. (P2)*

Participant 3 also expressed having a sense of chemistry with their music therapist. They made a distinction between music therapy and psychotherapy, which seemingly reflects the client-therapist relationship with their music therapist. They expressed that it is easier to create a trusting bond with their music therapist compared to other therapists due to the resource-oriented focus they experienced in music therapy:

> *Music therapy is more about, "What do you like? What do you want to try? What can you do? What can you practice? What can you get better at?" You are not as happy to say everything to a psychologist maybe, you do not trust them maybe. But in music therapy, you can actually go even further. (P3)*

Flexibility

The term "flexibility" was explicitly suggested to be a key factor in the client-therapist relationship by two of the participants and implicitly expressed by the two other participants. This term was either used directly to describe the importance of flexibility when deciding the activities in the music therapy sessions, or indirectly when describing the enjoyment of the perceived freedom and coordination in musical interactions with the music therapist. Commonly, it seemed that all the participants valued the flexibility of

being able to choose whether the music therapy session would accommodate space for talking, playing music, or both. When asked what they felt was important in the client-therapist relationship, one of the participants expressed:

> *That the therapist is flexible. Sometimes you just cannot create something creative, sometimes you just need to talk. Because the lives of the clients go up and down, and things happen. Sometimes you cannot speak, and [so you] just want to listen to music. [It is important] that one is then not judged. That the clients should not feel stupid if the full session goes to something other than what was originally planned. (P4)*

For others, flexibility in the form of musical improvisation with the music therapist was expressed as essential for the client-therapist relationship. Two of the participants explained that most of the communication happens when they improvise musically together with their music therapist. It was emphasised that in music playing, they "understood" each other without communicating verbally, which, according to the participants, was a contributing factor to a fulfilling client-therapist relationship due to the chemistry they felt during and after musical interactions. An example of this type of interaction was described as:

> *If we're making a song [through musical improvisation] for example and then we make something really cool, and then suddenly, "Here we need a bridge," and then we just make something... And then it's just like… "That was awesome." (P2)*

The other participant expressed that "great musical moments" is inspiring and contribute to strengthen the bond with their music therapist:

> *It's very inspiring when we jam together. The music can take you even further. To learn something, to achieve something, to master something. You feel greater freedom. It's not just words, it's not just talking. (P3)*

Collaboration

Two of the participants mentioned "collaboration" (between participant and music therapist, when playing music or doing musical projects like music production) as a positive factor impacting the client-therapist relationship. They both expressed that they felt like they were working *with* their music therapist, rather than the music therapist having a "teacher role." The client-therapist relationship for them was expressed as being built on the premise of equality and mutual recognition – a relationship in which the client and the music therapist consistently have things to teach each other. One of the participants exemplified this by saying:

> *I get immersed in the projects with the music therapist, and the music therapist gets immersed in my projects. I feel like we build each other up. The music therapist and I collaborate very well. (P1)*

The other participant expressed that:

> *It is very rewarding because then… You feel that we work with each other in the music. I do not feel like the music therapist is my "teacher," and I am the "customer." (P3)*

Main Theme 2: Feeling Safe and Being Challenged

The significance of feeling safe with the music therapist, expressed in various ways by the participants, emerged as a superordinating theme in all interviews. "Feeling safe and being challenged" comprises four subordinate themes: first impression when meeting the music therapist; the music therapist being honest; being vulnerable with the music therapist; and

the music therapist having control and musical competence in a therapeutic setting. The importance of feeling safe was expressed clearly:

> *For me, it's like that… It´s the feeling of safety, the feeling that you are seen, that you are listened to, that you feel like you can collaborate [with the music therapist]. (P1)*

Several of the participants also expressed that – granted that they experienced their relationship with their music therapist as safe – they wished to be challenged both musically and in conversations.

First impression

Two of the participants talked about the importance of the first impression and how that could be a deciding factor when choosing to continue working with a therapist or not. When talking about the "ideal" first meeting with a therapist, both participants suggested that they want to be met with eye contact and a smile, as for them that is a sign that they are welcome. One of the participants described directly what they need from the music therapist when first meeting to feel safe:

> *Radiate welcomeness, smile, and greet me. That is a good start, I think. (P1)*

Participant 4 described why the first impression matters to them, and what effect a good first impression can have on the client-therapist relationship:

> *I got a first impression that was completely on point. The music therapist had steady eye contact and a very pleasant aura. Everything was just in place. The relationship was there right away, the chemistry was very good, the aura felt very safe, and we had an instant connection. (P4)*

Honesty

Several of the participants brought up the word "honesty" as part of having a trusting client-therapist relationship. They want the music therapist to give honest feedback. They expressed that they do not want their music therapist to "pity them" or "sugar-coat" conversations, but rather always have expectations of them and their resources and believe in their ability to master given tasks or challenges during the sessions. Being honest and having expectations of the clients were expressed as respectable qualities for the music therapist to have. One participant was clear about wanting honest feedback:

> *It's good when the music therapist takes the lead and tells me, "I feel this way about this." Then I get some feedback that, okay, this is good, and this is not good. (P3)*

Another participant also stated clearly that they want honest feedback from the music therapist in order to feel respected:

> *I also like honest feedback. I want the music therapist to give feedback on whether I did something well or not because then I know that there are expectations that I can achieve something. You want feedback based on a stance that, "I believe you can accomplish this." (P4)*

Proceeding cautiously

Although several of the participants want honest feedback from their music therapist, the topic of vulnerability in music therapy was also a discussion in the interviews. Some of the participants pointed out that it is important to proceed cautiously when meeting with the clients, due to the "vulnerable state that they might be in" (P4), and that, in the context of music therapy, it is essential that the therapist has reflected upon the personal and

private aspect of music playing and song writing. It was explained that it is appreciated if the music therapist is humble when playing music because that signals to the clients that they do not have to perform or prove themselves in the music therapy sessions:

> *It should be like that… That you should not have to prove yourself. The security of not feeling that you must master something is very important. It's okay to play badly. (P4)*

Guidance, competence, and presence

A final topic that emerged during the interviews is the preferred "role" of the music therapist. Although several of the participants want the client-therapist relationship to be casual and friendly, the need for structure and/or for the music therapist to have some sort of control was emphasised by some of the participants. They exemplified this by expressing that they want the music therapist to be present, give advice and guidance both in conversation and in the music playing, know the clients well enough to understand what to do in cases where the clients experience symptoms, and generally have a structure for the sessions. For some, guidance from the music therapist was an essential part of the client-therapist relationship:

> *Sometimes the music therapist reflects for me. "Well, maybe next time you can think like this?" It's really good for me to be able to "get an extra hand" and to somehow be able to think a little differently than how my head usually thinks. (P1)*

The importance of the music therapist having the competence to know what to do in situations where the clients show symptoms was also expressed:

> *For me, a good relationship with the music therapist is extremely important. Because [symptoms] can come at any time, and then I need the music therapist to know what to do. (P4)*

Lastly, is it important for the participants that the music therapist is present in the moment and has a sense of control:

> *It is very important that the music therapist can also have control. For example, the client should not be anxious about the time [worrying about when the session ends]. (P4)*

Discussion

The present study aims to explore and gain new knowledge about the user perspective on what creates a working client-therapist relationship in the context of music therapy in mental healthcare. The findings suggest that the participants want and need a trusting client-therapist relationship in order for music therapy to be helpful. This is in line with studies within the field of psychotherapy that suggest that the "therapeutic relationship" can be described as the cornerstone of therapeutic change (Norcross, 2010). The data material was sorted into two main categories, namely *Power Relations* and *Feeling Safe and Being Challenged*, with subordinate themes. Four participants provided valuable perspectives on the client-therapist relationship in music therapy, which will be discussed in the following sections.

The topics of power relations and feeling safe in a client-therapist relationship are interwoven. All the findings in this study can be connected to power relations in one way or another, which is not surprising, given that a form of power imbalance seemingly is inevitable in every client-therapist relationship in therapy treatment. Nonetheless, the findings suggest that it is possible to achieve an equal relationship if mutual respect is apparent. However, it is important to note that the meaning of the term *equality* holds a different meaning depending on who you ask. Something which is collaborative, and

reciprocal is not necessarily equal. Several of the participants in this study did, however, use the term *equality* in their statements. When asked what they deemed important in a client-therapist relationship, all four participants discussed negative experiences with prior therapists. Participant 4 talked about how they perceived many psychologists to have a "black and white" way of thinking when treating clients. The perceived "rigidity" of psychotherapy, as experienced by several of the participants, could perhaps be linked to the field's deep roots in the medical model[4]. For instance, most psychologists working in mental healthcare follow specific treatment manuals (Wampold, 2013). Such manuals have, from a non-behaviourist stance on psychotherapy, been associated with "fixed sequences of techniques that should be applied in a rigid and inflexible manner" (Rolvsjord et al., 2005, p. 23). In Norway, psychologists are also required to follow strict ethical principles (Norsk psykologforening, 2022), which may give them less room for improvisation in a therapy setting and within the client-therapist relationship. Whereas psychotherapy traditionally has been regarded as an intervention process (Beutler & Clarkin, 2014), music therapy may in a broader sense afford collaboration. However, depending on the sites where they work, music therapists may also have guidelines they are required to follow that could limit the possibilities for improvisation or flexibility (see e.g., Waldon, 2016).

The topic of "collaboration rather than intervention" is a well-known concept in resource-oriented music therapy. Rolvsjord (2010) describes collaboration in music therapy as equality, mutuality, and participation. Collaboration in this sense entails shared responsibility, engagement, affective responsiveness, and for the client and the music therapist to both be active participants in the sessions. Both participants 1 and 3 emphasised that collaborating with their music therapist, either when doing musical projects or practising for a concert, was an important factor in the client-therapist relationship. Participant 1 showed how they contribute to the therapeutic relationship by saying, "I feel like we build each other up. The music therapist and I collaborate very well." Here, the participant is acknowledging the reciprocity of the client-therapist relationship, where both the participant, as well as the music therapist, play an active role. A mutual and collaborative relationship in therapy can be linked to empowerment, given that the focus in therapy then lies on the client's strengths rather than their weaknesses. Such equal relationships require contributions both from the client and the music therapist (Rolvsjord, 2010, 2016; Slade & Wallace, 2017; Sprague & Hayes, 2000).

The findings suggest that clear communication helps strengthen the client-therapist relationship in music therapy. What we say, how we say it (our tone of voice), our musical communication, as well as how we use our body language will inevitably affect the client-therapist relationship in one way or another. Participant 4 expressed that it is important for them that when the music therapist is using body language that can be misunderstood, such as yawning or sighing, the music therapist should communicate to the client that their body language (e.g., yawning) is not the result of anything to do with the client. Based on previous experiences of the opposite, the participant expressed that it is necessary for them to be reassured that they are still welcome when the music therapist is doing something that can easily be misinterpreted. This can be linked to the topic of experienced stigma[5] in mental health treatment. Studies of clinicians' and service users' experiences of mental health treatment suggest that there may, in some cases, be a pervasive stigma toward clients among mental health professionals (Foye et al., 2022; Ring & Lawn, 2019). Clients' accounts, in other studies, stated that staff at different mental health services, such as psychiatrists and nurses, engaged in disrespectful behaviour toward clients by making sarcastic remarks, ignoring them, radiating superiority, being aloof or expressing a dislike toward them (Rains et al., 2021; Strike et al., 2006). Their experiences of being disrespected by health professionals are consistent with the participants accounts for this study.

In addition to unfortunate or easily misinterpreted use of body language, the verbal language by health professionals when encountering clients can also be a contributing factor to the stigmatisation of people with mental health conditions (Pellegrini, 2014). Participants 1 and 4 expressed that the music therapist's language plays a big role. On the one hand, the language should not be too difficult to understand, and on the other hand, it should not be simplified to the extent that it can be perceived as degrading. Since there is a possibility that clients in music therapy have experienced stigmatising attitudes from health professionals in treatment, one can argue that the music therapist should reflect upon how communication can contribute to stigma in music therapy. Within the field of substance use, Romeo (2020) expresses in her dissertation that increased knowledge about substance use disorders – through additional education or experience – is a way to reduce substance use stigma. She suggests that "by increasing the number of presentations on substance use stigma, music therapists have the potential ability to reduce stigma in the field, since education has been shown to play a significant role in decreasing stigma" (p. 26). This point can also be transferred to the field of mental healthcare. Perhaps presentations and discussions on how communication can contribute to stigma in music therapy can be better integrated into the music therapy field and the education program for music therapy students as well.

The topic of friendship[6] in music therapy has been in discussion for decades (see e.g., Dileo, 2000; Foster, 2007; Lee, 2016). Music therapy may be perceived as informal, for instance, due to the casual conversations about common interests that often occur. This was the case for two of the participants in this study. Silverman (2019) conducted a study where he interviewed eight music therapists on how they develop a therapeutic alliance with adults in mental health settings. The results identified two categories that contributed to developing a therapeutic alliance: music factors (e.g., familiarity and preference of music) and non-music factors (e.g., being authentic during patient interactions). The music therapists' accounts of how to develop a therapeutic alliance correlate well with the participants' accounts in this study. Participants 2 and 3 expressed that they have developed chemistry or a sense of friendship with their music therapist due to the informality of their client-therapist relationship. These relationships were developed through common musical interests, and because the setting of music therapy generally allows the focus to be on, "*What do you like? What do you want to try? What can you do?*" (P3). Music therapy usually allows for greater versatility, and the possibilities for flexibility both in therapy and in the client-therapist relationship are many. However, reflections and/or discussions with other researchers or a trusted supervisor on the topic of boundaries in the therapeutic relationship should be required as "boundaries and ethical rules are necessary foundations for practice" (Forster, 2007, p. 20).

As previously mentioned, the themes of *Power Relations* and *Feeling Safe and Being Challenged* are interwoven. The clients' needs and wants should be respected in order to feel safe in a client-therapist relationship. The flexibility of music therapy, and what that implies should, according to participant 4, be made clear to the clients from the very beginning to facilitate a safe and comfortable environment. They directly suggested that the music therapy session should be flexible, given that some days call for conversations only, some for music only, and others for a mix of both. The clients should never be or feel judged for their choices either way. Consistent with participant 4's statements, a study of service users' experiences of music therapy in mental healthcare in Ireland showed that flexibility and adaptableness in the sessions were factors that made them feel acknowledged, respected, and accepted (McCaffrey, 2018).

The findings also suggest that flexibility in musical improvisation, where much of the communication happens intersubjectively[7], may strengthen the client-therapist relationship. Participant 3 expressed that they feel inspired and experience a sense of freedom when improvising musically with their music therapist due to the understanding

that happens between them without the use of words. Similarly, participant 2 talked about the understanding between themselves and the music therapist of how to make "cool music" without communicating verbally. This musical relating that can happen in the client-therapist relationship is a well-established concept within the field of music therapy. Trondalen (2016) explained, "An intersubjective perspective on relational music therapy highlights the therapeutic relationship established through music, which is interactive in nature" (p. 36).

In order to create a trusting client-therapist relationship, the clients need to feel safe, which for the participants in this study means that they are being seen/heard, can be vulnerable with their music therapist and do not feel the pressure to perform in therapy. In a meta-synthesis of 14 qualitative studies exploring clients' experiences of treatment for borderline personality disorder, Katsakou and Pistrang (2018) identify three domains, one of which is "helpful and unhelpful treatment characteristics" (p. 951). Three of the included studies elaborate on the topic of safety in the client-therapist relationship as a helpful treatment characteristic. For instance, the study by Langley and Klopper (2005) found certain factors that were thought by clients in psychiatric community services to be essential for the development of trust in the client-therapist relationship: "The clinician needed to be perceived as available and accessible, trying to understand by listening, caring, which conferred a feeling of being held and contained so that they felt emotionally and physically safe" (p. 26), which is similar to the accounts in this study. When discussing the feeling of safety in a client-therapist relationship, two of the participants also emphasised the importance of the first impression they get when meeting a new therapist, and how it is crucial that they instantly feel welcome. Wampold and Budge (2012) write, "Before the therapeutic work in psychotherapy can begin, an initial therapeutic bond is needed" (p. 604), which seems to be directly transferrable to the context of music therapy. A feeling of welcome may, according to the findings, be achieved through fundamental acts such as smiling and making eye contact with the clients. This is congruent with other clients' accounts which describe the affection that can exude from a smile when meeting someone for the first time, making them feel "cared for" (Castillo et al., 2013, p. 269).

Honest feedback in music therapy is valued by the participants if a trusting client-therapist relationship is in place. They connected honesty from the music therapist – both constructive and encouraging feedback – to them respecting the clients and believing that they can master challenges in therapy. Giving honest feedback can be linked to the music therapist's authenticity and to the music therapist's self-disclosure[8]. Rolvsjord (2010) proposes that "self-disclosure is a type of performance of authenticity in the therapeutic relation" and that "self-disclosure can be seen as a prerequisite for the client's openness, serving to build trust and openness, mutuality and intimacy" (p. 228). Giving honest feedback on the clients' musical performances may arguably be a form of self-disclosure, considering that the feedback is based on the music therapist's subjective preferences and/or professional opinions. Lastly, the participants expressed that guidance, competence, and presence are important qualities in treatment. They need to trust that the music therapist has a structure and a sense of control in order to feel safe in treatment. All these qualities mentioned above are in line with the guidelines for resource-oriented music therapy (Rolvsjord et al., 2005). They write, "There is a need to balance flexibility with structure" (p. 23), which is in line with the accounts of the clients participating in this study.

Implications

This study has provided findings that are congruent with existing literature, now from the perspectives of the clients. All the findings are unique in that a study that explores what

clients in mental healthcare find helpful in the client-therapist relationship in music therapy has, to my knowledge, never been done before. Nevertheless, there are some specific findings that I would like to highlight, that I find worth reflecting on. First, music therapists should be very aware of how they *communicate* with their clients. The findings suggest that our communication in terms of body language and use of words may either reduce or, conversely, contribute to the stigmatisation of the clients. *Collaboration* between the client and the music therapist is deemed as a positive factor impacting the client-therapist relationship. Trondalen (2016) points out the importance of creating a safe space with the clients in the first meeting. The findings in this study add to that by stressing the importance of the client's *first impression* of the therapist, and how the first impression may be crucial to whether the client wants to keep attending music therapy. Lastly, I would like to emphasise that it is important to also reflect on how we as *music therapists present our musical abilities* to the clients. One participant pointed out that they feel intimidated if the music therapist is showing that they are at a professional level musically, as it can be perceived as unattainable. While this may not be the case for all clients, it is nonetheless something to be aware of.

Conclusions

This article has explored four participants' perspectives on helpful characteristics of the client-therapist relationship in music therapy in mental health treatment. Overall, the study was coloured by the participants' prior experiences of power imbalance in mental health treatment, which afforded detailed accounts of what they need in a client-therapist relationship in order for the music therapy to be optimal. To not feel judged, the use of layman's language, informality, flexibility, and collaboration in music therapy is expressed by the participants as important elements for the client-therapist relationship. Further, the participants expressed that in order to create a *trusting* relationship, mutual respect between the client and the music therapist is crucial. When trust is established in the relationship, honesty and guidance from the music therapist are also desired. In general, the findings suggest that the participants want and value what could be considered fundamental social needs, such as feeling safe and being respected, and that these needs are important for there to be a good client-therapist relationship in music therapy. Based on these findings, I would argue that showing genuine respect for the clients as well as being present and authentic goes a long way in the client-therapist relationship in music therapy.

Acknowledgements

I would like to thank all four participants who took part in this study and their music therapists who helped me recruit participants. Thanks are also due to my partner in crime and fellow music therapist student, Irmelin Nielsen, who gave me helpful critical insights during the preparation of this article. Lastly, I would like to thank my master's supervisor, Kjetil Hjørnevik, for his very useful input and guidance.

About the Author

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[1] See Rolvsjord (2010, p. 20) or Maddux (2002) for elaboration.

[2] Though the term *user involvement* is not specifically employed in their book, some of the core concepts of community music therapy are participation and empowerment, both of which are strongly linked to the concept of user involvement.

[3] A Norwegian expression for "putting someone in a box."

[4] Wampold (2013, pp. 13–14) asserts that the medical model has five components: 1. The problem belongs to the client, 2. The therapist is the expert, 3. Each psychotherapeutic approach posits a mechanism of change, 4. There exist specific therapeutic ingredients, 5. Those therapeutic ingredients are the client's cure.

[5] For elaboration on the topic of stigma in music therapy in mental health care, see Tuastad et al. (2022).

[6] For an elaborated critical reflection on the concept of friendships in music therapy relationships, see Forster, 2007.

[7] Intersubjectivity concerns creating nonverbal mental contact, a shared awareness and understanding between people (Stern, 2004).

[8] Meaning that the music therapist is sharing something personal as part of a mutual therapeutic relationship (Rolvsjord, 2010, p. 228).